STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	03/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 18, 19, 20, 21 and 22, 2013 Facility number: 000135 Provided number: 155230 AIM number: 100266820 Survey team: Sharon Lasher RN, TC Angel Tomlinson RN Barbara Gray RN Leslie Parrett RN Census bed type: SNF/NF: 65 Total: 65 Census payor type: Medicare: 14 Medicaid: 40 Other: 11 Total: 65 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/01/13 by Suzanne Williams, RN	F000000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 4/10/13. **Rosebud Village** respectfully requests the state consider the following evidentiary information be considered in deleting the deficiency F 325. Rosebud Village is requesting a paper IDR review. The current 2567 statement of deficiencies omits pertinent facility information and therefore misrepresents the services administered by the provider. **F 325 Nutrition Federal Regulation states: Based on a resident's comprehensive assessment, the facility must ensure that a resident-- §483.25(i)(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and §483.25(i)(2) Receives a therapeutic diet when there is a nutritional**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			problem. State Operations Manual Interpretive Guidelines for F 325 Acceptable parameters of nutritional status" refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis. "Avoidable/Unavoidable" failure to maintain acceptable parameters of nutritional status: o "Unavoidable" means that the resident did not maintain acceptable parameters of nutritional status even though the facility had evaluated the resident's clinical condition and nutritional risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. " • "Insidious weight loss" refers to a gradual, unintended, progressive weight loss over time. **End-of-Life** Resident choices and clinical indications affect decisions about the use of a feeding tube at the end-of-life. A resident at the end of life may have an advance directive addressing his or her treatment goals (or the resident's surrogate or representative, in accordance with State law, may have made a decision). Decreased appetite and altered hydration are common at the end of life, and do not require interventions other	

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			than for comfort. Multiple organ system failure may impair the body's capacity to accept or digest food or to utilize nutrients. Thus, the inability to maintain acceptable parameters of nutritional status for someone who is at the end-of-life or in the terminal stages of an illness may be an expected outcome. Care and services, including comfort measures, are provided based on the resident's choices and a pertinent nutritional assessment. The facility can help to support intake, to the extent desired and feasible, based on the information from the assessment and on considering the resident's choices. If individualized approaches for end-of-life care are provided in accordance with the care plan and the resident's choices, then the failure to maintain acceptable parameters of nutritional status may be an expected outcome for residents with terminal conditions. **The deficient practice statement states:** Based on observation, interview, and record review, the facility failed to follow or implement new interventions for a resident with weight loss for 1 of 2 residents reviewed for weight loss of 5 who met the criteria for weight loss. (Resident #50). **Evidence to Refute the Finding** Resident 50 1. Resident #50 was admitted to the facility on 7/21/2009. Resident's primary diagnoses are bilateral renal	

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			artery stenosis, type II diabetes, hypertension, chronic renal insufficiency, carotid artery disease, history of constipation, Alzheimer's dementia with behavioral disturbances, and insomnia. (Attachment A). 2. Resident #50 dietary physician orders included the following; regular diet with large breakfast, peanut butter and jelly sandwich at bedtime, salt substitute per resident request and offer bedtime snack. (Attachment A) 3. Resident #50 nutritional assessments completed by the Registered Dietician included the following; meds, labs and vitamins reviewed by hospice with orders to discontinue or change. (Attachment C) 4. Resident #50 nutritional care plan included the following, see attachment. (Attachment D) 5. Resident #50 received an order for hospice services which states; may admit resident to hospice, to keep resident comfortable, PRN medications, monitor pain, scoop mattress, may discontinue calcium supplement with vitamin D, may d/c CBC and LFT's labs every March and September on March 8 th , 2013. (Attachment E) 6. Resident # 50 health was deteriorating as evidence from the social service notes, and nursing notes dated 2/6/13, 2/11/13, 3/07/13, and 3/20/13. (Attachment F) 7. The record reflects that Resident 50 has experienced a 7 pound weight	

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			loss between April 2012 and April 2013. However all appropriate measures were taken to ensure this Resident was provided with adequate nutrition and encouraged to consume meals, snacks and fluids of her choice (Attachment G). 8. Resident food intake is monitored daily as evidence by daily vitals reports, which includes all of the residents meal intakes for the last 3 1/2 months to current date (Attachment H). 9. Resident #50 labs were monitored as evidence by routine labs (Attachment J). 10. Resident #50 annual nutritional assessment were completed and stated that resident's personal goal weight is 125#. RD's assessment indicates that resident #50 ideal body weight is between 108-132# (Attachment K). **Conclusion:** Residents #50's weight and food intake were being monitored. Resident #50 experienced unavoidable weight loss due to the resident's deteriorating physical condition and the acceptance of participation in the Hospice Program. The resident's labs were drawn and monitored. The resident had order dietary snacks. The facility made continuous dietary changes and interventions to help the resident achieve their highest practicable well being. The facility provided the resident with assistance to eat. Therefore, Rosebud Village does not believe	

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			it should have been cited for F 325, and therefore requests F 325 be deleted. Thank you for your consideration. Joni Howell, HFA Executive Director	

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F000241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview and record review, the facility failed provide care in a manner that promoted dignity, related to the failure to answer call lights in a timely manner and provide care in a timely manner for 11 of 26 residents interviewed regarding if they felt there were enough staff available to ensure care and assistance needed was done without waiting a long time (Residents #39 #54 #82 #57 #46 #84 #74 #5 #25 #62 & #32). Findings include: 1.) Review of the record of Resident #39 on 3-20-13 at 2:10 p.m. indicated the resident's diagnoses included, but were not limited to, degenerative joint disease, pain, arthritis, anxiety, panic disorder, depression and history of right proximal hip fracture. The Minimum Data Set (MDS) assessment for Resident #39 dated 1-30-13, indicated the following: the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range	F000241	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 4/10/13. **F 241DIGNITY AND RESPECT OF INDIVIDUALITY** The facility must promote care for residents in amanner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *Residents#39 #54 #82 #57 #46 #84 #74 #5 #25 #62 & #32 were not harmed by alleged deficient practice. *All staff has been provided with re-education related to call light response time and expectations of facility that all staff is to answer call lights, conducted by	04/10/2013

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	of 13-15 indicating the resident was cognitively intact, the resident required extensive assistance of two people to transfer, walk in room-activity did not occur, and required extensive assistance of one person for dressing, toilet use, and personal hygiene. Interview with Resident #39 on 3-18-13 at 10:56 a.m. indicated it "always" took staff a long time to answer her call light. Resident #39 indicated her bedroom was located at the end of the hall and staff tell her they cannot see her call light. Resident #39 indicated there had been several times it has taken up to two hours for the call light to be answered. 2.) Review of the record of Resident #54 on 3-20-13 at 2:30 p.m. indicated the resident's diagnoses included, but were not limited to, macular degeneration, osteoarthritis, osteoporosis, hypertension, visual impairment, gait impairment and history of frequent falls. The MDS assessment for Resident #54 dated 2-3-13, indicated the following: the resident's BIMS was a 13, with a range of 13-15 indicating the resident was cognitively intact,		DNS/designee on April 10, 2013. *All residents #39 #54 #82 #57 #46 #84 #74 #5 #25 #62 & #32 call lights are being answered timely by staff. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff has been inserviced by the Director of Nursing and/or designee on call light response time and facility expectations of all staff answering call lights by April 10, 2013. * Call light response audits will be conducteddaily on all 3 shifts by the Director of Nursing and/or designee to capture response time on each shift. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** *Facility expectation that all staff must answer call lights * All staff has been inserviced by the Director of Nursing and/or designee on appropriate call light response time and facility expectation that all staff must answer call lights, conducted by April 10, 2013. * Call light response audits will be conducted daily on all 3 shifts by the Director of Nursing and/or designee to capture response time on each shift. *DNS/designee will conduct	

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	transfer - activity occurred only once or twice with the assistance of one person, walk in room - did not occur, locomotion on the unit - total dependence of one person, dressing - extensive assistance of one person, toilet use - extensive assistance of two people, and personal hygiene - extensive assistance of one person. Interview with Resident #54 on 3-18-13 at 10:30 a.m. indicated it frequently took staff an hour to answer call lights. Resident #39 indicated it occurs on all shifts at the facility. 3.) Review of the record of Resident #82 on 3-21-13 at 10:45 a.m. indicated the resident's diagnoses included, but were not limited to, osteoporosis, compression fracture of L2 vertebral body, dry eyes, lumbar spinal stenosis (narrowing), osteoarthritis and depression. The MDS assessment for Resident #82 dated 2-1-13 indicated the following: transfer - extensive assistance of one person, walk in room - activity did not occur, and dressing, toilet use and personal hygiene - extensive assistance of one person.		rounds to monitor call light response time daily on all 3 shifts to ensure call lights are answered in a timely manner. * The Director of Nursing is responsible for compliance. * Non-compliance with appropriate call light response time will result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * An Accommodation of Needs CQI tool will be utilized by Director of Nursing/designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months. * Audit tools that do not exceed threshold of 90% will be submitted to the CQI committee and action plans will be developed as needed.	

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	Interview with Resident #82 on 3-19-13 at 10:27 a.m. indicated he had to wait for assistance to go to the bathroom for up to one hour. The resident indicated he was unable to wait that long to go to the bathroom and this had caused him to be incontinent of his bladder. 4.) Review of the record of Resident #57 on 3-21-13 at 11:00 a.m. indicated the resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), osteoporosis, hypertension and degenerative joint disease. The MDS assessment for Resident #57 dated 2-22-13 indicated the following: transfer- extensive assistance of two people, walk in room- activity did not occur, dressing- extensive assistance of one person, toilet use- extensive assistance of two people and personal hygiene- extensive assistance of one person. Interview with Resident #57 on 3-19-13 at 11:44 a.m. indicated she did not feel there was enough staff to provide care and assistance without waiting a long time. Resident #57 indicated she had to wait longer than 15 minutes before staff answered her call light.			

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	5.) Review of the record of Resident #46 on 3-22-13 at 2:00 p.m. indicated the resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), bladder cancer, anxiety, pain and depression. The MDS assessment for Resident #46 dated 2-15-13 indicated the following: the resident's BIMS was a 15, with a range of 13-15 indicating the resident was cognitively intact, transfer- extensive assistance of two people, walk in room, personal hygiene and dressing - extensive assistance of one person, and toilet use - extensive assistance of two people. Interview with Resident #46 on 3-18-13 at 11:14 a.m. indicated it took staff a long time to answer call lights. Resident #46 indicated it takes between 15 to 20 minutes for staff to answer her call light. Resident #46 indicated she could not wait that long to go to the bathroom. Resident #46 indicated she had bladder cancer and felt that her bladder was "weak". Resident #46 indicated she knew how long it took staff to answer her call light, because she would time it by her clock on the wall or her watch.			

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	Confidential interview with staff #1 on 3-20-13 at 9:56 a.m. indicated there was not always enough staff to to give the residents timely care. Confidential interview with staff #3 on 3-20-13 at 3:15 p.m. indicated there was not enough staff to provide repositioning, incontinent care and skin care to residents in a timely manner. Staff #3 indicated residents were already wet by the time call lights could be answered. Staff #3 indicated it could take up to twenty minutes before call lights can be answered. Confidential Interview with staff #4 on 3-20-13 at 3:18 p.m. indicated residents' call lights cannot be answered timely. Confidential staff #4 indicated when aides were in a room giving care they could hear the call lights going off, but were unable to answer them, because they were in the middle of giving care to another resident. Confidential interview with staff #5 on 3-21-13 at 1:45 p.m. indicated the residents did not receive care and assistance in a timely manner. 6.) An interview was conducted with Resident #84, on 3/18/13 at 9:52 A.M. Resident #84 stated "I feel they are			

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	understaffed. They come as soon as they can and that is understandable. Sometimes there is an emergency and such." Resident #84 indicated she would turn her call light on and staff would come to her room and say "it will be just a minute" and would leave her room. She indicated they would return 10 to 15 minutes later and sometimes later than that. Resident #84's record was reviewed, on 3/22/13 at 4:30 P.M. Diagnoses included, but were not limited to, inability to ambulate with neuropathy due to vitamin B-12 deficiency and diabetic neuropathy. Resident #84's admission Minimum Data Set (MDS) assessment, dated 12/26/12, indicated the following: Resident #84 had the ability to understand and was understood by others. She scored 15 on her Brief Interview for Mental Status (BIMS), indicating she was cognitively intact. She required extensive assistance of two persons for bed mobility, transfers, and toilet use. She did not walk. She was frequently incontinent. 7.) An interview was conducted with Resident #74, on 3/18/13 at 10:17 A.M. Resident #74 stated "sometimes I put my call light on but			

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	no one answers. I will yell out that I need to go to the bathroom and then usually someone shows up to take me to the bathroom." Resident #74's record was reviewed, on 3/20/13 at 8:49 A.M. Diagnoses included, but were not limited to, vascular dementia, osteoarthritis, diabetes, hypertension, congestive heart failure, and chronic debility. Resident #74's admission MDS assessment, dated 1/11/13, indicated the following: Resident #74 had the ability to understand and was understood by others. He scored 12 on his BIMS, indicating his cognitive status was moderately impaired. He required extensive assistance for bed mobility, transfer, and toilet use. He required extensive assist of one person to walk. He was continent of his bowel and bladder. 8.) An interview was conducted with Resident #5, on 3/18/13 at 11:00 A.M. Resident #5 was queried if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait a long time. Resident #5 stated "I gotta say no." She indicated she waited approximately 20 minutes during busy times.			

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	Resident #5's record was reviewed, on 3/20/12 at 11:33 A.M. Diagnoses included, but were not limited to, multiple sclerosis, chronic obstructive pulmonary disease, transverse myelitis with secondary paraplegia, diabetes, and chronic pain syndrome. Resident #5's significant change MDS assessment, dated 12/31/12, indicated the following: Resident #5 had the ability to understand and was understood by others. She scored 15 on her BIMS, indicating she was cognitively intact. She required extensive assist of two persons for bed mobility. Transferring and walking did not occur. She required total assistance of one person to toilet. 9.) An interview was conducted with Resident #25, on 3/18/13 at 11:46 A.M. Resident #25 was queried if she felt there was enough staff available to make sure she got the care and assistance she needed without having to wait a long time. Resident #25 stated her wait was "sometimes a long time, because they're busy." Resident #25 indicated she used the bedpan most of the time and had to be transferred with the use of a lift.			

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	155230	A. BUILDING 00 B. WING	03/22/2013

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Resident #25's record was reviewed, on 3/22/13 at 4:35 P.M. Diagnoses included, but were not limited to, acute respiratory failure, diabetes, and end stage renal disease.

Resident #25's admission MDS assessment, dated 2/15/13, indicated the following: Resident #25 had the ability to understand and was understood by others. She scored 12 on her BIMS, indicating her cognitive status was moderately impaired. She required extensive assistance of two persons for bed mobility, transfer, and toilet use. She was occasionally incontinent of urine. She did not walk.

10.) An interview was conducted with Resident #62, on 3/18/13 at 1:06 P.M. Resident #62 was queried if he felt there was enough staff available to make sure he got the care and assistance he needed without having to wait a long time. Resident #62 indicated he sometimes had to wait 15 to 20 minutes, and sometimes longer.

Resident #62's record was reviewed, on 3/20/13 at 10:07 A.M. Diagnoses included but were not limited to Parkinson's disease, orthostatic

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	hypotension, arthritis, and back problems. Resident #62's quarterly MDS assessment, dated 1/8/13, indicated the following: Resident #62 had the ability to understand and was understood by others. He scored 11 on his BIMS, indicating his cognitive status was moderately impaired. He required limited assistance of 1 person for bed mobility, transfer, and toilet use. He was occasionally incontinent of urine. He required supervision with set up help to walk. 11.) The record of Resident #32 was reviewed on 3/20/13 at 2:00 p.m. Resident #32's diagnoses included, but were not limited to diabetes, urinary urgency, coronary artery disease, chronic back pain and osteoarthritis. Resident #32's MDS, assessment, dated 12/15/12, indicated the following: - BIMS, (Brief Interview for Mental Status), 15, a score of 13-15, indicating cognition intact - transfer, extensive assistance with two+ person physical assist - walk in room and corridor, extensive assistance with one person physical assist			

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	- toilet use, limited assistance, one person physical assist - current toileting program, no - urinary continence, occasionally incontinent - bowel continence, frequently incontinent of bowel During an observation on 3/20/13 at 1:20 p.m. Resident #32 was observed in her wheelchair facing her bed side commode transferring herself from the wheelchair to the bed side commode. As soon as Resident #32 stood up she was incontinent of urine before she got turned around to sit on the bed side commode. During an interview on 3/20/13 at 1:20 p.m. Resident #32 stated "the girls are too busy here they don't answer the call lights for a long time. Sometimes it is one to 2 hours before they get to me and I can't wait that long. I have my watch on and I know how long it takes." During an interview on 3/21/13 at 3:08 p.m., Resident #32's family member stated "it takes a long time to get help here they have too much to do to get to her and a lot of times it is over and hour." 3.1-3(t)			

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F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview and record review, the facility failed to provide restorative services for ambulation for 1 of 1 resident reviewed for rehabilitation of 16 residents who met the criteria for rehabilitation. (Resident #32) Findings include: The record of Resident #32 was reviewed on 3/20/13 at 2:00 p.m. Resident #32's diagnoses included, but were not limited to, diabetes, urinary urgency, coronary artery disease, chronic back pain, and osteoarthritis. Resident #32's MDS (Minimum Data Set) assessment, dated 12/15/12, indicated a BIMS (Brief Interview for Mental Status) assessment score of 15, with a score of 13-15 indicating cognition intact. The MDS also indicated Resident #32 needed extensive assistance with one person's physical assistance for ambulation.	F000311	**F 311 TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS** A resident is given the appropriate treatment and services to maintain or improve his or her abilities. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident #32 was not harmed by alleged deficient practice.*All staff inserviced on restorative programs on April 10, 2013.*Resident #32 is participating in physical therapy per physician's order.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All	04/10/2013

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	Resident #32's care plan, dated 12/17/12, indicated "Problem, resident needs assistance with ADLs (Activities of Daily Living) related to decreased mobility. Goal, resident will present a neat, clean appearance daily, allow adequate time for resident to complete task, assist/provide oral care twice daily and as needed, encourage resident to do as much for self as possible, assist to complete tasks as needed, refer to therapies as ordered/required, set up required equipment within reach." On 3/20/13 at 1:20 p.m., Resident #32 was observed transferring by herself from her wheelchair to her bed side commode. She took small steps and was slow but did transfer herself from the wheelchair to the bed side commode. During an interview on 3/21/13 at 1:30 p.m. LPN #11 indicated "(Resident #32) never walks. I don't think she wants to." During an interview on 3/21/13 at 3:15 p.m., Physical Therapist #12 indicated Resident #32 was discharged from Physical Therapy on 12/10/12 and discharged from the Restorative program on 1/18/13.		staff inserviced by the Director of Nursing and/or designee on restorative programs and maintaining ADLs on April 10, 2013* All residents in facility will be assessed for need of a restorative program and implement program as needed by April 10, 2013. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * All staff inserviced by the Director of Nursing and/or designee on restorative programs and maintaining ADLs on April 10, 2013* Director of Nursing and/or designee will assess all residents in facility for need of a restorative program and implement program as needed by April 10, 2013. *MDS coordinator and/or designee will reassess any resident who refuses restorative to ensure restorative needs are being met and determine acceptance of restorative programs. * MDS coordinator and/or designee will conduct rounds to ensure residents are receiving restorative programs as assessed.* The MDS coordinator and/or designee is responsible for compliance related to restorative program initiation. **How will the corrective action(s) be**	

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	Resident #32's "Restorative Flowsheet" indicated 15 minutes of AROM (Active Range of Motion), on 1/12, 1/13, and 1/14, 2013 and 15 minutes of a walking on 1/12, 1/13 and 1/14, 2013. During an interview on 3/22/13 at 2:05 p.m., CNA #10 indicated the staff do not walk Resident #32 and stated "I think she is on restorative." During an interview on 3/22/13 at 1:45 p.m., Resident #32 indicated the staff do not get her up and walk her. "Since I came over here from the Medicare side they have walked me one time about 40 feet and it felt good to be up. I need to be walking. I am not going to be able to walk if they don't walk me." During an interview on 3/23/13 at 1:00 p.m., Physical Therapist #13, stated "I know why (Resident #32) was taken off the Restorative care. She refused 3 times on two different days and if the resident refuses 3 times after three days we drop them from Restorative." During an interview on 3/23/13 at 2:05 p.m., the DON indicated there was no documentation of Resident #32 being ambulated after 1/14/13 by		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * An Accommodation of Needs CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months. * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if threshold of 90% is not met.	

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	nursing. 3.1-38(a)(2)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to thoroughly assess or develop effective approaches for bladder training for 2 of 3 residents reviewed for bladder training of 6 residents who met the criteria for bladder function. (Resident #32 and #83) Findings include: 1.) The record of Resident #32 was reviewed on 3/20/13 at 2:00 p.m. Resident #32's diagnoses included, but were not limited to, diabetes, urinary urgency, coronary artery disease, chronic back pain and osteoarthritis. Resident #32's MDS (Minimum Data Set) assessment, dated 12/15/12, indicated the following: - BIMS (Brief Interview for Mental	F000315	**F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER** Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **What corrective action(s) will**	04/10/2013

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	Status), 15, a score of 13-15 indicating cognition intact - transfer, extensive assistance with two+ person physical assist - walk in room and corridor, extensive assistance with one person physical assist - toilet use, limited assistance, one person physical assist - current toileting program, no - urinary continence, occasionally incontinent - bowel continence, frequently incontinent of bowel Resident #32's MDS assessment, dated 10/6/12, indicated Resident #32 was always continent of urine and always continent of bowel. Resident #32's care plan, dated 10/17/12, indicated "Problem, resident is at risk for incontinence due to extensive assist with ADLs (Activities of Daily Living), diagnoses of urinary urgency. Goal, Resident will be free from adverse effects of incontinence. Approach 1/23/13, toilet upon rising, before or after meals, before bed and as needed (also provide assistance per her request), assess and document skin condition weekly and as needed, assist with incontinent care as needed, check every 2 hours for		**be accomplished for those residents found to have been affected by the deficient practice?** * Resident #32 and #83 were not harmed by alleged deficiency practice. * Resident #32 and #83 were reassessed and approaches developed to enhance bladder training. * All staff was provided re-education on how to identify toilet programs for each resident.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff was inserviced by the Director of Nursing and/or designee on toileting programs on April 10, 2013. * Audits will be conducted weekly to ensure CNAs are carrying CNA assignment sheets on them during work hours.* Director of Nursing and/or designee will reassess all completely incontinent residents with 3-day voiding patterns to ensure all residents needing bladder retraining have appropriate interventions. **What measures will be put into place or what systemic**	

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	incontinence, document any abnormal findings and notify physician and observe for signs of urinary tract infection: decreased output, concentrated urine, abdominal/flank pain, difficult/painful urination, frequency, change in mental status, fever, increase in incontinence." On 3/20/13 at 1:20 p.m. Resident #32 was observed in her wheelchair facing her bed side commode transferring herself from the wheelchair to the bed side commode. As soon as Resident #32 stood up, she was incontinent of urine before she got turned around to sit on the bed side commode. During an interview on 3/21/13 at 11:19 a.m., Resident #32 stated "I take myself to the bed side commode most of the time. Just like this morning the CNA said she would bring the bed pan but she didn't come back so I had to get up by myself and use the bed side commode. I don't make it and go some on the floor because once I get up I can't always hold it. No, they don't come in and ask me if I have to go to the bathroom I just go myself." During an interview on 3/21/13 at		**changes you will make to ensure that the deficient practice does not recur?** . * All Staff wasinserviced by theDirector of Nursing and/or designee on toileting programs and use of CNA assignment sheets on April 10, 2013. * Audits will be conducted weekly to ensure CNAs are carrying CNA assignment sheets on them during work hours. * Director of Nursing and/or designee will reassess all completely incontinent residents with 3-day voiding patterns to ensure all residents needing bladder retraining have appropriate interventions. * Director of Nursing and/or designee will add interventions to the CNA assignment sheets.* The Director of Nursing is responsible for compliance related to ensuring toileting programs are being followed. * Non-compliance of toileting programs by staff may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * An Accommodation of Needs CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly	

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	1:24 p.m., LPN #11 stated "no, we don't get her up to use the bed side commode on a regular basis but sometimes she does call for assistance." During an interview on 3/22/13 at 11:28 a.m., CNA #10 indicated the staff do not get Resident #32 up to use the bed side commode most of the time, but they provide assistance per her request. During an interview on 3/22/13 at 2:20 p.m., the ADON (Assistant Director of Nursing) indicated Resident #32 was on a toilet program to toilet upon rising, before or after meals, before bed and as needed (also provide assistance per her request). 2.) Resident #83's record was reviewed, on 3/21/13 at 8:56 A.M. Diagnoses included, but were not limited to, respiratory failure, chronic obstructive pulmonary disease, congestive heart failure, end stage renal disease, and chronic pain syndrome. Resident #83's admission Minimum Data Set (MDS) assessment, dated 10/24/12, indicated the following. Resident #83 had the ability to understand and understood others.		X1 for at least 6 months. * Audit tools will be submitted to the CQI committee and action plans will be developed as needed when a threshold of 90% is not met.	

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	He required limited assistance of one person for bed mobility, transfer, and toilet use. He was always continent of his bladder. He required supervision with set up help only to walk. A care plan for Resident #83, dated 10/29/12, indicated the following: "Problem-Resident is at risk for incontinence due to: limited assist with activities of daily living (ADL's). Long term goal-Resident will be free from adverse effects of incontinence. Approaches-Assess and document skin condition weekly and as needed. Assist with incontinent care as needed. Check every 2 hours for incontinence. Document any abnormal findings and notify MD. Observe for signs of urinary tract infection." Resident #83's significant change MDS assessment, dated 1/29/13, indicated the following. Resident #83 had the ability to understand and understood others. He required extensive assistance of 1 person for bed mobility, transfer, and toilet use. He was occasionally incontinent. He was not on a toileting program e.g. scheduled toileting, prompted voiding, or bladder training. He required limited assistance of 1 to walk.			

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	An interview with the Assistant Director of Nursing (ADON) on 3/22/13 at 12:10 P.M., indicated if a resident began having episodes of incontinence, the facility would request labs to see if an acute medical condition was present. The resident would be treated according to what abnormal labs pertained to incontinence. The resident would be referred to therapy for an assessment and if there was a true change in incontinence, the resident would be referred to restorative. An interview with the ADON on 3/22/13 at 2:28 P.M., indicated Resident #83 had not had any lab draws related to his incontinence. She indicated she read nursing notes daily and was not aware of his incontinence. She indicated his incontinence was not addressed because his incontinence episodes were sporadic, and not continual. She indicated if he was having continual incontinence, he would have been referred to therapy. She indicated he had not been referred to therapy related to his incontinence. She indicated he was not on a toileting schedule or a toileting restorative program.			

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	An interview with the Director of Nursing (DoN), on 3/22/13 at 2:45 P.M., indicated she had not been informed Resident #83 was having episodes of incontinence. She indicated she should be informed of a residents continence decline when it appears on their MDS assessment. The Bladder Program, provided by the DoN, on 3/22/13 at 4:21 P.M., indicated the following: "Policy: It is the policy to promote independence and dignity with an appropriate bladder program based upon each resident's ability. Procedure: 1.) Each resident will have a 3-day voiding pattern initiated within 72 hours of admission and/or any change in continence status. 2.) A new 3-day voiding pattern will only be completed if there is a change in level of continence including when a catheter is removed. 3.) The resident should be checked and offered toileting every hour during waking hours; checked every two hours during the night during the 3 days of the voiding pattern. 4.) The charge nurse on each shift is responsible for overseeing the 3 day voiding pattern... 5.) The MDS Coordinator/Unit Manager should review the voiding patterns on a daily basis to determine pattern,			

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	compliance, and continence status. > If it is determined at the end of the 1st day the resident is totally incontinent and cannot be placed on a toilet or bedpan (or use a urinal) due to physical limitations and inability to comprehend, discontinue the voiding pattern and provide routine incontinent care. >If it is determined at the end of the 1st day the resident is totally continent, discontinue the voiding pattern. 6.) A bladder assessment will be completed upon admission, and quarterly thereafter. 7.) After completion of the 3 day pattern the MDS Coordinator/Unit Manager will complete the bladder assessment evaluation and determine if the resident is a candidate for one of the following. >Check and change (routine incontinence care). >Scheduled toileting program. >Formal bladder re-training program. Check and change: >If a resident is totally incontinent and unable to be placed on a toilet or bedpan, resident should be checked and changed every two hours. Scheduled toileting program: >If a voiding pattern can be determined, develop an individualized resident specific program, update the care plan and resident care records/assignment sheets. >If a voiding pattern cannot be determined, resident should be toileted upon			

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	rising, before and after meals, and at bedtime. Bladder Retraining Program: 1.) A resident should be considered for a bladder re-training program if the following conditions are met: >A voiding pattern could not be established. >Resident is mentally and physically aware of the need to void and be able to use the toilet, commode, urinal, or bedpan. >Resident is mentally and physically able to resist voiding to attempt a bladder retraining program. 2.) If a resident is considered to be a candidate to a bladder re-training program, follow the guidelines below: >Consult with the resident/family member for permission to start the program. >Obtain a physician's order to start the program. >Obtain an order for a UA and resolve any UTI prior to beginning the program. >Based upon the resident's normal and required fluid intake, determine the amount of fluid to be provided over the 24 hour period. >Determine a time in the evening that no fluids will be provided. >Review the 3-day voiding pattern to determine a pattern of voiding. >Begin bladder retraining by instructing the resident to resist voiding for the amount of time that was determined by the 3 day voiding pattern. >Instruct resident to resist voiding for 2 hours until successful,			

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	then increase the intervals by an hour each day. >Update the care plan to include goals for voiding intervals and fluid regulation pattern. >Document fluids and voiding times on the I & O record...." 3.1-41(a)(2)			

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement a fall intervention of keeping a resident within eyesight while in a wheelchair for 1 of 3 residents reviewed for falls of 7 residents who met the criteria for accidents(Resident #18). Findings include: 1.) Review of the record of Resident #18 on 3-21-13 at 11:10 a.m. indicated the resident's diagnoses included, but were not limited to, dizziness, Alzheimer, osteoporosis, hypertension and vertebral kyphoplasty. The Minimum Data Set (MDS) assessment for Resident #18 dated 1-22-13 indicated the following: transfer- extensive assistance of two people, walk in room- activity did not occur, locomotion on the unit- total dependence of one person, dressing- extensive assistance of one person, toilet use- extensive assistance of two	F000323	**F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident #18 was not harmed during the alleged deficiency practice.* Resident #18 has all current fall interventions updated and implemented per plan of care.*Resident #18 CNA assignment sheets were updated. **How will you identify other residents having the potential**	04/10/2013

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	people and personal hygiene-extensive assistance of one person. The event report for Resident #18 dated 3-8-13 at 7:45 p.m. indicated the resident was found laying on her right side at the foot of her bed on the floor in her bedroom. The resident had a 5 centimeter by 3 centimeter skin tear (no description of a location of the skin tear) and 6 steri strips applied. The resident's right shoulder was swollen and the resident grimaced when her shoulder was moved. The physician was called and an x-ray of her right shoulder was ordered. The event report for Resident #18 dated 3-9-13 at 10:30 a.m. indicated the resident's steri strips were in place to the right side of her forehead. The Interdisciplinary team (IDT) event report for Resident #18 dated 3-11-13 at 2:17 p.m. indicated the IDT met to review the resident's fall that occurred on 3-8-13. The resident was found on the floor face down on her right side at the foot of the bed. The resident had a skin tear to the right side of her face and her right shoulder was swollen. The resident received 6 steri strips to her forehead. The x-ray of the resident's shoulder was		**to be affected by the same deficient practice and what corrective action will be taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff wasinserviced by the Director of Nursing and/or designee on fall prevention and interventions on April 10, 2013*Assistant Director of Nursing and/or designee updated all CNA assignment sheets to ensure all appropriate interventions were listed and implemented. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** * All staff wasinserviced by the Director of Nursing and/or designee on fall prevention and interventions on April 10, 2013. * Audits will be conducted daily on all 3 shifts to ensure fall interventions are in place for each resident by Director of Nursing and/or designee.* The Director of Nursing is responsible for compliance related to fall interventions. * Non-compliance by staff to ensure appropriate fall interventions are followed may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	negative for a fracture. Upon investigation of the resident's fall the staff had wheeled the resident to her room and went to get assistance from another staff to transfer the resident to her bed. The immediate intervention implemented was the staff were to assist the resident to bed directly after meals. The IDT added the intervention of the resident to remain within eyesight of staff until the resident was ready for transferring back to bed. The care sheet and careplan revised. During observation on 3-21-13 at 1:45 p.m. Resident #18 was sitting in her wheelchair in the TV room. There were no staff or other residents in the TV room. Resident #18 was not in eyesight of any staff. The TV room is located down the hall and around the corner from the nursing station. Resident #18 had a bandage on the right side of her forehead. Interview with CNA #5, #6 and #7 on 3-21-13 at 1:55 p.m. indicated they were all assigned to care for Resident #18. CNA #5, #6, and #7 indicated they were not aware that Resident #18 was supposed to be within eyesight of staff until she was ready to lay down. When queried how were fall interventions communicated to the		* A Fall Program CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months. * Audit tools will be submitted to the CQI committee and action plans will be developed as needed when the threshold of 90% is not met.	

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	aides, CNA #6 indicated it would be documented on the care sheet. CNA #6 provided the care sheet at this time, and it did not have any documentation for Resident #18 to remain within eyesight of staff until she was ready to lay down. Interview with the Assistant Director Of Nursing (ADON) on 3-21-13 at 1:57 p.m. indicated she was responsible to update the CNAs' care sheets with fall interventions to communicate the residents' fall interventions to the staff. The ADON indicated she did not add the fall intervention of keeping Resident #18 within eyesight of staff until the resident was ready to lay down. The ADON indicated she would update Resident #18's care sheet at this time. During observation on 3-22-13 at 9:45 a.m. Resident #18 was sitting in her wheelchair in the TV room with her head down and her eyes closed. The resident was not within eyesight of any staff. Resident #18 had a bandage on the right side of her forehead. Interview with the ADON on 3-22-13 at 10:10 a.m. indicated she had updated Resident #18's care sheet			

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	for her to be kept within eye sight until she was ready to lay down. The ADON indicated the CNAs were supposed to review the care sheet every morning so they would know of any changes made. The ADON indicated she did not know why Resident #18 was not within eyesight of the staff. The ADON wheeled Resident #18 down to the nursing station at this time. Review of a document titled Fall Management Program provided by the Administrator on 3/22/13 at 11:15 a.m., indicated: It is the policy of American Seniors Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to falls. Procedure: Fall Risk: 4. Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift. Post fall: 4. a fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions.			

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	An entry will be completed in the EMR (electronic medical record) addressing the fall, any injuries, physician and family notification and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the fall to determine other possible interventions to prevent future falls. 3.1-45(a)(2)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review, the facility failed to follow or implement new interventions for a resident with weight loss for 1 of 2 residents reviewed for weight loss of 5 who met the criteria for weight loss. (Resident #50) Findings include: The record of Resident #50 was reviewed on 3/20/13 at 11:15 a.m. Resident #50's diagnoses included, but were not limited to, diabetes, coronary artery disease, Alzheimer's dementia, bilateral renal artery stenosis and renal insufficiency. Resident #50's MDS (Minimum Data Set), assessment, dated 2/1/13, indicated BIMS, (Brief Interview for Mental Status), 7, a score of 8-12 indicating moderate impairment of cognition. Resident #50's eating	F000325	**F 325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** * Resident #50 was not harmed during the alleged deficiency practice. * Resident #50 receives all dietary supplements as orderedby physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/10/2013

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	indicated limited assistance. Resident #50's care plan, dated 3/14/13, "problem, resident is now receiving Hospice Care. Resident leaves 25-50% of meals creating risk for unintentional weight loss. Contributing factors diagnoses diabetes, bilateral renal artery stenosis, Alzheimer's dementia, coronary artery disease and renal insufficiency." Resident #50's physician orders, dated 5/13/12, "regular diet, consistent carbohydrate/double entree/salt substitute," 1/10/13, Remeron (antidepressant) 7.5 mg (milligrams), for depression and 11/29/11, "peanut butter and jelly sandwich at bedtime." Resident #50's document titled "weight record" indicated the following: - 11/1/12, 129, pounds - 12/3/12, 134, pounds - 1/2/13, 129, pounds - 2/1/13, 132, pounds - 3/5/13, 127, pounds - 3/19/13, 122, pounds During an interview on 3/20/13 at 11:20 a.m., the Dietary Manager indicated Resident #50 was not		**taken.** * Residents who reside in this facility have the potential to be affected by the alleged deficient practice. * All staff was inserviced by the Director of Nursing and/or designee on identifying risk for weight loss in residents on April 10, 2013. *Dietary Manager and/or designee will conduct a facility audit on all tray cards to ensure accuracy by April 10, 2013 to ensure residents are provided with diet as prescribed by physician. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** *All Staff have been inserviced by the Director of Nursing and/or designee on identifying risk for weight loss in residents on April 10, 2013. * A manager is assigned by Executive Director and/or designee to each meal to identify any changes in residents and/or ensure all appropriate current interventions are carried out at meals in dining room and room trays. *Dietary Manager and/or designee will conduct a facility audit on all tray cards to ensure accuracy by April 10, 2013 to ensure residents are provided with diet as prescribed by physician. * Dietary Manager is responsible for compliance related to all interventions for weight losses are implemented. * Non-compliance with weight loss	

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	receiving a dietary supplement. Resident #50's dietary assessment, dated 3/14/13, indicated "March weight 127, shows gradual weight loss in 30 days but stable. Resident has been admitted to Hospice for care. Resident to receive a regular diet with large portions at breakfast and peanut butter and jelly sandwich at bedtime. Will add whole milk to meals when menued resident's intake has decreased somewhat. Most meals consumes 25-50% with set-up." During an observation on 3/20/13 at 11:15 a.m., CNA #9 was cueing Resident #50 to eat some of her lunch. Resident #50 took a few bites of her food and CNA #9 took the fruit from Resident #50's tray and left it on her bedside table for later. Resident #50 indicated she wasn't hungry and did not eat anymore. During an interview with the Dietary Manager on 3/20/13 at 11:30 a.m., the Dietary Manager indicated the interventions since Resident #50 started losing weight were, on 5/13/12 double entree portions, 11/29/11, peanut butter and jelly sandwich at bedtime, 1/10/13 Remeron 7.5 mg and 3/11/13 whole milk at meals.		interventions being implemented may result in further education, and/or disciplinary action. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** * A Meal Service Observation CQI tool will be utilized by Director of Nursing and /or designee weekly x 4 weeks, monthly x 2 months and quarterly X1 for at least 6 months. * Audit tools will be submitted to the CQI committee and action plans will be developed as needed if a threshold of 90% is not met. **Rosebud Village** respectfully requests the state consider the following evidentiary information be considered in deleting the deficiency F 325. Rosebud Village is requesting a paper IDR review. The current 2567 statement of deficiencies omits pertinent facility information and therefore misrepresents the services administered by the provider. **F 325 Nutrition Federal Regulation states: Based on a resident's comprehensive assessment, the facility must ensure that a resident-- §483.25(i)(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and**	

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	During an observation on 3/22/13 at 11:50 a.m., Resident #50 did not have milk on her lunch tray. During an interview with the Dietary Manager on 3/22/13 at 11:57 a.m., the Dietary Manager indicated Resident #50 only receives milk on her tray when milk is on the menu. 3.1-46(a)(1)		**§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem. State Operations Manual Interpretive Guidelines for F 325** Acceptable parameters of nutritional status" refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis. "Avoidable/Unavoidable" failure to maintain acceptable parameters of nutritional status: o "Unavoidable" means that the resident did not maintain acceptable parameters of nutritional status even though the facility had evaluated the resident's clinical condition and nutritional risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. " • "Insidious weight loss" refers to a gradual, unintended, progressive weight loss over time. **End-of-Life** Resident choices and clinical indications affect decisions about the use of a feeding tube at the end-of-life. A resident at the end of life may have an advance directive addressing his or her treatment goals (or the resident's surrogate or representative, in accordance with State law, may have made a decision). Decreased appetite and altered hydration are	

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			common at the end of life, and do not require interventions other than for comfort. Multiple organ system failure may impair the body's capacity to accept or digest food or to utilize nutrients. Thus, the inability to maintain acceptable parameters of nutritional status for someone who is at the end-of-life or in the terminal stages of an illness may be an expected outcome. Care and services, including comfort measures, are provided based on the resident's choices and a pertinent nutritional assessment. The facility can help to support intake, to the extent desired and feasible, based on the information from the assessment and on considering the resident's choices. If individualized approaches for end-of-life care are provided in accordance with the care plan and the resident's choices, then the failure to maintain acceptable parameters of nutritional status may be an expected outcome for residents with terminal conditions. **The deficient practice statement states:** Based on observation, interview, and record review, the facility failed to follow or implement new interventions for a resident with weight loss for 1 of 2 residents reviewed for weight loss of 5 who met the criteria for weight loss. (Resident #50). **Evidence to Refute the Finding** Resident 50 1. Resident #50 was admitted to the facility on	

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	155230	A. BUILDING 00 B. WING	03/22/2013

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			7/21/2009. Resident's primary diagnoses are bilateral renal artery stenosis, type II diabetes, hypertension, chronic renal insufficiency, carotid artery disease, history of constipation, Alzheimer's dementia with behavioral disturbances, and insomnia. (Attachment A). 2. Resident #50 dietary physician orders included the following; regular diet with large breakfast, peanut butter and jelly sandwich at bedtime, salt substitute per resident request and offer bedtime snack. (Attachment A) 3. Resident #50 nutritional assessments completed by the Registered Dietician included the following; meds, labs and vitamins reviewed by hospice with orders to discontinue or change. (Attachment C) 4. Resident #50 nutritional care plan included the following, see attachment. (Attachment D) 5. Resident #50 received an order for hospice services which states; may admit resident to hospice, to keep resident comfortable, PRN medications, monitor pain, scoop mattress, may discontinue calcium supplement with vitamin D, may d/c CBC and LFT's labs every March and September on March 8 th , 2013. (Attachment E) 6. Resident # 50 health was deteriorating as evidence from the social service notes, and nursing notes dated 2/6/13, 2/11/13, 3/07/13, and 3/20/13. (Attachment F) 7. The record	

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			reflects that Resident 50 has experienced a 7 pound weight loss between April 2012 and April 2013. However all appropriate measures were taken to ensure this Resident was provided with adequate nutrition and encouraged to consume meals, snacks and fluids of her choice (Attachment G). 8. Resident food intake is monitored daily as evidence by daily vitals reports, which includes all of the residents meal intakes for the last 3 1/2 months to current date (Attachment H). 9. Resident #50 labs were monitored as evidence by routine labs (Attachment J). 10. Resident #50 annual nutritional assessment were completed and stated that resident's personal goal weight is 125#. RD's assessment indicates that resident #50 ideal body weight is between 108-132# (Attachment K). **Conclusion:** Residents #50's weight and food intake were being monitored. Resident #50 experienced unavoidable weight loss due to the resident's deteriorating physical condition and the acceptance of participation in the Hospice Program. The resident's labs were drawn and monitored. The resident had order dietary snacks. The facility made continuous dietary changes and interventions to help the resident achieve their highest practicable well being. The facility provided the resident with assistance to	

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			eat. Therefore, Rosebud Village does not believe it should have been cited for F 325, and therefore requests F 325 be deleted. Thank you for your consideration. Joni Howell, HFA Executive Director	